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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

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MICHAEL W. DOBBINS
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Econ Williams

(Enter above the full name
of the plaintiff or plaintiffs in
this action)

08CV1588

JUDGE LINDBERG

MAG. JUDGE DENLOW

vs.

Cas. _____
(To be supplied by the Clerk of this Court)

Harley Lampkin
Mr. Scabana, Warden
Ginger Jones, Med. Admin.

(Enter above the full name of ALL
defendants in this action. Do not
use "et al.")

CHECK ONE ONLY:

_____ **COMPLAINT UNDER THE CIVIL RIGHTS ACT, TITLE 42 SECTION 1983**
U.S. Code (state, county, or municipal defendants)

✓ **COMPLAINT UNDER THE CONSTITUTION ("BIVENS" ACTION), TITLE**
28 SECTION 1331 U.S. Code (federal defendants)

_____ **OTHER (cite statute, if known)**

BEFORE FILLING OUT THIS COMPLAINT, PLEASE REFER TO "INSTRUCTIONS FOR FILING." FOLLOW THESE INSTRUCTIONS CAREFULLY.

I. Plaintiff(s):

- A. Name: Eeon Williams
- B. List all aliases: _____
- C. Prisoner identification number: 10185-026
- D. Place of present confinement: Metropolitan Correctional Center
- E. Address: 71 W. Buren Street - Chicago, IL 60605

(If there is more than one plaintiff, then each plaintiff must list his or her name, aliases, I.D. number, place of confinement, and current address according to the above format on a separate sheet of paper.)

II. Defendant(s):

(In A below, place the full name of the first defendant in the first blank, his or her official position in the second blank, and his or her place of employment in the third blank. Space for two additional defendants is provided in B and C.)

- A. Defendant: MR. HARLEY LAMPKIN
 Title: DIRECTOR OF THE BUREAU OF PRISONS
 Place of Employment: FEDERAL BUREAU OF PRISONS
- B. Defendant: MR. SCABANA
 Title: WARDEN
 Place of Employment: OXFORD FEDERAL CORRECTIONAL CENTER
- C. Defendant: GINGER JONES
 Title: MEDICAL ADMINISTRATOR
 Place of Employment: OXFORD FEDERAL CORRECTIONAL CENTER

(If you have more than three defendants, then all additional defendants must be listed according to the above format on a separate sheet of paper.)

III. List ALL lawsuits you (and your co-plaintiffs, if any) have filed in any state or federal court in the United States:

- A. Name of case and docket number: _____

- B. Approximate date of filing lawsuit: _____
- C. List all plaintiffs (if you had co-plaintiffs), including any aliases: _____

- D. List all defendants: _____

- E. Court in which the lawsuit was filed (if federal court, name the district; if state court, name the county): _____
- F. Name of judge to whom case was assigned: _____

- G. Basic claim made: _____

- H. Disposition of this case (for example: Was the case dismissed? Was it appealed? Is it still pending?): _____

- I. Approximate date of disposition: _____

IF YOU HAVE FILED MORE THAN ONE LAWSUIT, THEN YOU MUST DESCRIBE THE ADDITIONAL LAWSUITS ON ANOTHER PIECE OF PAPER, USING THIS SAME FORMAT. REGARDLESS OF HOW MANY CASES YOU HAVE PREVIOUSLY FILED, YOU WILL NOT BE EXCUSED FROM FILLING OUT THIS SECTION COMPLETELY, AND FAILURE TO DO SO MAY RESULT IN DISMISSAL OF YOUR CASE. CO-PLAINTIFFS MUST ALSO LIST ALL CASES THEY HAVE FILED.

IV. Statement of Claim:

State here as briefly as possible the facts of your case. Describe how each defendant is involved, including names, dates, and places. **Do not give any legal arguments or cite any cases or statutes.** If you intend to allege a number of related claims, number and set forth each claim in a separate paragraph. (Use as much space as you need. Attach extra sheets if necessary.)

*See the "Statement of Claim"
enclosed (10) pages*

Statement Of Claim

While I was incarcerated as a prisoner, in the Federal Bureau Of Prisons, Oxford Federal Correctional Institution, I was exposed to potentially deadly disease called Community-Associated Staphylococcus Aureus, "CA-MRSA" otherwise known as Methicillin Resistant Staphylococcus Aureus.

On approximately May 27th, 2003 I noticed what appeared to be small red, pimple like bumps on my arm and legs. I submitted the proper forms in which to see the doctor immediately, because I was aware of what a staph infection looked like, having seen other inmates at this facility with the disease.

When I saw the doctor (Dr. James Reed), within 48 hours of submitting a request to get medical attention, I told him that I suspected that the infection was "Staph." However, after an inspection of the infected areas on my body, Reed told me that I was having an allergic re-action to something, maybe it was the soap I was using, or even the water. I questioned his opinion because I had never had an allergic re-action to soap or had such bumps before appear on my skin.

Dr. James Reed, an employed doctor and/or medical health care provider, at Oxford F.C.I. made a diagnosis solely from a visual inspection, and told me that the infections were in fact caused by an allergic re-action, and was not "Staph". Reed then prescribed for me "Bene dryl" as medication for the treatment of the infection.

It should be noted: The doctor "Reed" did not properly diagnosis my infection as MRSA, which is what it turned out to be. Reed did not take a tissue sample of the infected area, or a nasal secretion for signs of drug-resistant bacteria, as is required by the Department of Health in making a proper diagnosis.

The failure to make a proper diagnosis of the infection, and to prescribe proper treatment of medication, has placed me at an increase risk of this life-threatening skin infection.

Two days after the mis-diagnosis, when I woke up in the morning, the bump area had become worst and had turned into an abs's about $\frac{1}{2}$ inch wide, and my arm had

swollen up twice the size, and the pain that I was experiencing was intolerable.

It was on a Wednesday when I originally noticed the infection and filed requests to see the doctor. It was on that Friday, 48 hours later when I saw the doctor. It was on Sunday, two days later that my infection had progressed and got worst. With an improper diagnosis and while on medication that was not for the treatment of "Staph", the infection grew worst. It was a holiday weekend, and the medical department would be closed on Monday, and the doctor would not return until Tuesday.

Therefore, on Sunday morning I sought immediate medical attention, and even though there were no doctors available, I was seen by a physician assistant, "P.A." who saw me on an emergency status. The P.A. saw the wound and determined it to be "MRSA", he took a culture of it, and he cleaned the wounds, and bandaged my arm. I was provided "tylenol" for the pain that I was experiencing, and instructed to come back the following day, to have the wound drained and cleaned, and re-bandaged.

I was also given additional bandages or gauze, and some triple antibacterial ointment, for me to self-treat my wound after showering.

On Monday, the following day, I went back to the health service department for additional treatment by the P.A. who was on duty. My wound on my arm was treated, as it was drained, cleaned, and it was ointed with some kind of unidentified white cream, applied to the wound. It was re-banded, and I was instructed to return to sick-call the following morning which would be on "Tuesday." At that time I was placed on "convalescence" for only a few days, and also instructed to stay away from engaging in sports activities that may cause me to sweat, because sweating may spread it, then I was sent back to my housing unit.

On Tuesday, I went to see the P.A. at the health services department, they took a wooden Q-tip, and dug the core out of the lesion on my arm, at that time, the P.A. said that my wound was in fact staph infection, but they were still waiting on the results of the culture to see what antibiotics

they could prescribe, he then consulted the doctor, and I was prescribed "Cipro" at the time. After the drainage of my wound, I was bandaged up again, and given some triple antibacterial ointment, also provided more gauze and tape, then sent back to my housing unit.

I took the antibiotics for seven (7) days as prescribed and everything seemed like it was clearing up, but three (3) days after the treatment of the antibiotics ended, the bumps and lesions returned. This time the lesions appeared under my arms and on my legs and knees. I requested to return to sick-call, they prescribed me more antibiotics, gave me more gauze and triple antibiotic ointment. They also instructed me to keep my hands, clothes, and living area clean. I was sent back to work, and instructed to return back to health services so that someone could examine my wounds again and to drain and clean them.

The Administration of Oxford F.C.I. including Warden Scabana, and the Medical Administrator Ginger Jones were reckless in their handling of my medical care, and jail conditions lead to me being exposed to this deadly disease.

It is my view that the jail conditions at Oxford F.C.I. were as such that other inmates who had the skin infection known as MRSA, were not being medically isolated. Infected inmates remained in population, this policy and practice placed me in harms way, and ultimately lead to me contracting this potentially deadly disease.

This administration was negligent in it's handling of my health and safety. The increased risk to staph also known as MRSA, happened as a direct result of these conditions and practices.

It should be noted: Staphylococcus Aureus, or "staph" as it is sometimes called, is a common bacterium found on the skin or in the nose of 25-30% of humans. While it is usually harmless, in certain instances it may cause moderate to severe skin infections. Less commonly, it causes more serious systemic infections e.g., bloodstream, surgical wound and pneumonia requiring hospitalization. One group of staph known as MRSA, methicillin-resistant Staphylococcus Aureus, was first identified in the 1960's, and is now prevalent in most hospitals. The organisms known as beta lactams, as well as other antibiotic families, and are therefore cause

for consideration and concern. Because of resistance, vancomycin has often been the only drug able to successfully treat these MRSA infections.

(See Exhibit # A-01, Alliance for the Prudent Use Of Antibiotics, "Update on antibiotic resistant Staph aureus.")

I was not provided the proper medication or antibiotics to treat the disease, and this lead to the reoccurrences of the disease. I was not treated with vancomycin.

It should be noted: Staphylococcus aureus (MRSA), or the Superbug. It is resistant to most standard antibiotics and becoming more resistant to newer ones. MRSA is now the most common cause of skin infections in the majority of American cities, says Dr. G. Moran, University of California, Los Angeles, David Geffen School of Medicine. He believes doctors should be giving patients who need antibiotics only those known to effectively combat MRSA. He says things have changed over the last ten years - a different type of bacteria is now the most common cause of infection.

(See Exhibit # A-02, Medical News Today)

It should be noted: Staphylococcus is a group of bacteria, familiarly known as Staph (pronounced staff), that can cause a multitude of diseases as a result of infection of various tissues of the body. Staph bacteria can cause illness not only directly by infection (such as in the skin), but also indirectly by producing toxins responsible for food poisoning and toxic shock syndrome. Staph related illness can range from mild and requiring no treatment to severe and potentially fatal.

(See Exhibit #A-03, Medicine Net. com, "Superbug Staph Spread in Community")

The above listed report gives a number of other diseases caused by staph.

The conditions in Oxford F.C.I.'s dayrooms, cells, restrooms and living quarters has lead to the wide spread of MRSA. This coupled with a failure to educate inmates concerning the preventative measures to protect themselves. I was never educated on staph while at this facility, and was UNAWARE of how to protect myself, or how I could become contaminated with this potentially deadly disease.

It should be noted: Like other staph infections, MRSA is passed from person to person through direct contact with skin or through contact with contaminated items. The bacteria may live in people's noses and on their skin, and usually don't cause any problems. However, young children, the elderly and individuals with immune deficiencies are at particular risk.

- What can be done to prevent MRSA infections?
- Facility Maintenance Recommendations
- EPA-registered disinfectant, cleaner and sanitizer

(see Exhibit #A-04, MRSA Cleaning Products)

The administration of Oxford F.C.I. allowed prison conditions to exist that had the potential contaminate surfaces with MRSA. The inmates who have MRSA are left in housing units, and as a direct result the spread of MRSA on surfaces throughout the living quarters adds to the spread of disease from inmate to inmate. At issue are hard surfaces and equipment such as floors, drinking fountains, toilets, light switches, door handles, handrails, tables and desks should be cleaned routinely using properly EPA-registered disinfectant cleaner and sanitizer.

It should be noted: Due to the highly contagious nature of MRSA, hospitals and prisons have become a breeding ground:

According to the Centers for Disease Control and Prevention, health care-associated infections account for an estimated 1.7 million infections and 99,000 associated deaths each year in American hospitals, and prisons.

(see Exhibit #A-05, The Healia Health Blog)

When I state that my life was placed at an increase risk of death. The above listed facts prove my case.

(see Exhibit #A-06, Mayo Clinic.com)

This report cites other risk factors that lead to being involuntarily exposed to this deadly disease.

This image shows a blank sheet of white paper with horizontal blue or grey ruling lines. A single black diagonal line runs from the top-left corner towards the bottom-right corner, intersecting the horizontal lines. The paper appears to be a standard notebook page.

V. Relief:

State briefly exactly what you want the court to do for you. Make no legal arguments. Cite no cases or statutes.

The defendants ARE being sued in both their individual and official capacities. I am asking the court to AWARD me Ten Million Dollars \$10,000,000.00 in both punitive and compensatory damages, for the pain and suffering associated with being contaminated with this disease.

VI. The plaintiff demands that the case be tried by a jury. ☒ YES ☐ NO

CERTIFICATION

By signing this Complaint, I certify that the facts stated in this Complaint are true to the best of my knowledge, information and belief. I understand that if this certification is not correct, I may be subject to sanctions by the Court.

Signed this 10th day of MARCH, 20 08

Eeon Williams

(Signature of plaintiff or plaintiffs)

Eeon Williams

(Print name)

#10185-026

(I.D. Number)

Metropolitan Correctional Center

71 West Van Buren Street

Chicago, Illinois 60605

(Address)

Exhibit #A-01

Alliance For The Prudent Use Of Anti-
biotics

"Update on Antibiotic-Resistant Staph
AUREUS"

3 Pages



APUA

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Update on antibiotic-resistant *Staph aureus*

New threats within the community

Staphylococcus aureus, or "staph" as it is sometimes called, is a common bacterium found on the skin or in the nose of ~25-30% of humans. While it is usually harmless, in certain instances it may cause moderate to severe skin infections. Less commonly, it causes more serious systemic infections e.g., bloodstream, surgical wound and pneumonia requiring hospitalization. One group of staph known as MRSA, (methicillin-resistant *Staphylococcus aureus*) was first identified in the 1960's, and is now prevalent in most hospitals. The organisms are resistant to multiple antibiotics (specifically, all antibiotics known as beta lactams, as well as other antibiotic families), and are therefore cause for considerable concern. Because of resistance, vancomycin has often been the only drug able to successfully treat these MRSA infections.

A newer form of staph infection, known as CA-MRSA (for community-acquired, or community-associated *Staphylococcus aureus*) has appeared with increasing frequency and is now epidemic within certain community populations. Whereas hospital MRSA is almost always found in persons with established risk factors associated with prior medical treatment, these are not present in CA-MRSA. Today, in the U.S. a little more than 10% of all MRSA infections are CA-MRSA. This form causes serious skin and soft tissue infections in otherwise healthy persons who have not been recently hospitalized or undergone invasive medical procedures. Hospitalization is required in approximately one out of five cases. CA-MRSA has been identified most frequently among specific populations, including prisoners, athletes, children, men who have sex with men, military recruits, Pacific Islanders, Alaskan Natives and Native Americans.

A major difference between the two types of MRSA is that the community form (CA-MRSA) possesses a potent toxin called Panton-Valentine leukocidin, which attacks infection-fighting white blood cells called leukocytes. The most serious form of CA-MRSA infection causes necrotizing fasciitis, a severe, rapidly progressing and life-threatening skin infection. The CA-MRSA are genetically distinguishable from hospital associated MRSA.

In the US, two clones (strains) of staph, called USA300 and USA400, are associated with the community MRSA (CA-MRSA). USA300 has emerged as the most prominent clone and is not found among hospital strains. It was not observed before the year 2000, when multiple other clones existed.

Treating MRSA. Treatment of MRSA skin infections is challenging. In some patients, skin ointments containing antibiotics, such as mupirocin or

fusidic acid, can be used, but resistance to these can develop. Beta-lactam antibiotics (i.e., methicillin and oxacillin), which are typically used to treat common Staph aureus infections (such as furuncles, abscesses, and cellulitis), are ineffective. Unlike hospital MRSA, which is resistant to multiple classes of antibiotics, (including macrolides, aminoglycosides, fluoroquinolones, tetracyclines and lincosamides), CA-MRSA is still susceptible to several antibiotic classes outside of the beta-lactam group (e.g., clindamycin).

In the hospital, because of multidrug resistance, intravenous vancomycin has become the drug of choice. Except for sporadic cases of vancomycin-resistant MRSA (VRSA), all MRSA are susceptible to this antibiotic. Unfortunately, the increasing use of vancomycin threatens to increase the VRSA problem.

Prevention

The spread of skin MRSA infections occurs most frequently through close, skin-to-skin contact (such as that found in contact sports), through contact with skin wounds (cuts, abrasions) and through contact with contaminated items, where staph can survive for 24 hours or more. The organisms can enter healthy, intact skin. Crowded living conditions and poor hygiene are factors which play a role in its spread. Currently, the only known means of prevention is through the following:

- Prudent hygiene measures involving hand washing
- Proper wound care, including proper disposal of bandages, and
- Avoidance of sharing certain personal items such as towels and razors. Shared exercise equipment should be wiped down between users.

For more information on the various forms of MRSA, the risk factors involved and prevention advice, visit Centers for Disease Control: http://www.cdc.gov/ncidod/hip/aresist/ca_mrsa.htm

Also see: APUA Newsletter, Focus CA-MRSA
www.tufts.edu/med/apua/Newsletter/APUA_v21n2.pdf

Research

CA-MRSA and Sports:

Recurring Methicillin-resistant Staphylococcus aureus Infections in a Football Team

Methicillin-Resistant Staphylococcus aureus Infections Among Competitive Sports Participants --- Colorado, Indiana, Pennsylvania, and Los Angeles County, 2000--2003

CA-MRSA and Correctional Facilities:

Methicillin-Resistant Staphylococcus aureus Infections in Correctional Facilities -- Georgia, California, and Texas, 2001-2003 (see page 12)

Antibiotics and MRSA:

Antibiotic Selection for Infections Involving Methicillin-Resistant Staphylococcus aureus

What does CA-MRSA look like?

Digital photographs of skin infections and wounds caused by community-associated methicillin resistant *Staphylococcus aureus* (MRSA/Staph).

ALLIANCE FOR THE PRUDENT USE OF ANTIBIOTICS © 1999

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Exhibit # A-02

Medical News Today

"Staph Superbug Most Common Cause Of U.S.
Skin Infections"

3 Pages



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Staph Superbug Most Common Cause Of US Skin Infections

★ Featured Article

Main Category: MRSA / Drug Resistance

Also Included In: Infectious Diseases / Bacteria /

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Article Date: 17 Aug 2006 - 9:00 PST

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It is known
as
Methicillin-
resistant

Staphylococcus aureus (MRSA), or the Superbug. It is resistant to most standard antibiotics and is becoming more resistant to newer ones. MRSA is now the most common cause of skin infections in the majority of American cities, says Dr. G Moran, University of California, Los Angeles, David Geffen School of Medicine. He believes doctors should be giving patients who need antibiotics only those known to effectively combat MRSA. He says things have changed over the last ten years - a different type of bacteria is now the most common cause of infections.

You can read about this in the *New England Journal of Medicine (NEJM)*, August 17 issue.

Related Article Info

News For This Category

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Assistance Program
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Proteins That Help Bacteria
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Scientists
26 Feb 2008

First New Topical Antibiotic
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MRSA used to be known as just the 'Hospital Superbug'. It was found just in hospitals, nursing homes and some other health care facilities. It was very rarely found in the community - what is known as 'community associated infection' with MRSA used to be extremely rare. This is not the case any more. There are more and more cases of MRSA acquired in the community - outside hospitals.

MRSA is not an uncommon bacteria. Apparently about one third of us, and maybe more, carry it around with us in our nose, on our skin and in our throat. Most of the time it is harmless. However, it can occasionally lead to serious and potentially fatal infections. Something as insignificant as a paper-cut can lead to MRSA infection.

The most common sign of Community-Associated MRSA infection is a boil or pimple on the skin. It is often swollen, red, has a discharge, and is painful.

Researchers cultured soft-tissue infections from 422 patients at emergency rooms in 11 US cities. The first time any such study had been done of so many US cities.

59% of all those patients had MRSA infection. Infection rates in those 11 cities varied from 15% to 74%. 97% of the MRSAs were of one strain, called USA-300.

The researchers had expected MRSA to be the most common infection among the 422 patients. However, they were surprised that the USA-300 strain was so common throughout the country.

The following percentages of MRSA samples could be treated with the antibiotics listed below:

- 100% trimethoprim-sulfamethoxazole
- 100% rifampin
- 95% clindamycin
- 92% tetracycline
- 60% fluoroquinolones
- 6% erythromycin

However, 57% of the patients had been prescribed antibiotics which were useless against the MRSA - in other words, the MRSA was resistant to 57% of the antibiotics doctors had prescribed for the 422 people. Hence, doctors should prescribe antibiotics which are known to be effective against MRSA, because MRSA infection is now the most common skin infection in the USA.

There are many steps we can take to reduce the incidence of MRSA infection in the community. It all comes down to a question of basic hygiene. Wash your hands regularly with soap. You can go even further by not sharing towels and some other toiletries.

What is MRSA?

Staphylococcus aureus, a type of bacteria, is present in many people and generally causes no problems. If it gets inside the body, however, such as under the skin it can cause serious infections. If it gets into the lungs it can cause severe pneumonia. People who carry Staphylococcus aureus are generally healthy, and are just 'carriers'.

When Staphylococcus aureus becomes resistant to commonly used antibiotics it is called Methicillin-resistant Staphylococcus aureus (MRSA). Many years ago the most common antibiotic used to treat Staphylococcus aureus was Methicillin. Methicillin is no longer used as an antibiotic, except in identifying drug resistant Staphylococcus aureus.

Most healthy people will never get seriously ill from this bacteria. However, some people can, including children, seniors (the elderly) and people with weakened immune systems, such as people with diabetes or HIV.

Methicillin-Resistant S. aureus Infections among Patients in the

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NEJM Volume 355:666-674 - August 17, 2006 - Number 7
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Written by: Christian Nordqvist

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Exhibit #A-03

Medicine Net. com

"Superbug Staph Spread in Community"

3 Pages



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Staph Infection Share your opinions with MedicineNet (Staphylococcus Aureus) and you could win \$500!

Medical Author: Melissa Conrad Stöppler, MD

Medical Editor: William C. Shiel, Jr., MD, FACP, FACEP

- What is Staphylococcus?
- Who is at risk for Staph Infection?
- What are the symptoms and signs of a Staph infection?
- What types of diseases are caused by Staph?
- How are Staph infections diagnosed?
- How are Staph infections treated?
- What is antibiotic-resistant Staph aureus?
- What are complications of Staph infections?
- Related Staph Infection Information

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What types of diseases are caused by Staph?

How are Staph infections diagnosed?

How are Staph infections treated?

What is antibiotic-resistant Staph aureus?

What are complications of Staph infections?

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Doctor to Patient

Superbug Staph Spread in Community

Medical Author: Melissa Conrad Stöppler, MD
Medical Editor: Barbara K. Hecht, PhD

MRSA, or methicillin-resistant *Staphylococcus aureus*, is a bacterium that can cause serious infections. It is resistant to numerous antibiotics of the beta-lactam family, including methicillin and penicillin.



MRSA belongs to the large group of bacteria known as *Staphylococci*, often referred to as Staph. About 25%-30% of all people have Staph within the nose, but it normally does not cause an infection. In contrast, only about 1% of the population have MRSA.

Infections with MRSA are most common in hospitals and other institutional health-care settings, such as nursing homes, where they tend to strike older people, those who are very ill, and people with a weakened immune system. In health-care settings, MRSA is a frequent cause of surgical wound infections, urinary tract infections, bloodstream infections (sepsis), and pneumonia.

MRSA outbreaks, however, are appearing increasingly in the community. Infections can occur in people who have not been hospitalized or had a medical procedure performed in the past year, and who do not have immune deficiency. These infections are termed community-associated MRSA infections (CA-MRSA). The U.S. Centers for Disease Control and Prevention (CDC) estimates that about 12% of MRSA infections are now community-associated, but this percentage can vary by community and patient population.

Learn about symptoms of MRSA infections

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Staph Infection

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Staph Infections are a growing problem in US hospitals. Though they typically start as mild skin infections, they can be deadly. Here are some tips to help you protect yourself.

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at greater risk, including newborn infants, breastfeeding women, and people with chronic conditions such as diabetes, cancer, vascular disease, and lung disease. Injecting drug users, those with skin injuries or disorders, intravenous catheters, surgical incisions, and those with a weakened immune system all have an increased risk of developing Staph infections.

TOP SEARCHED STAPH INFECTION TERMS:
contagious, symptoms, hospitals, types, Staphylococcal infections, children, MRSA



What are the symptoms and signs of a Staph infection?

Staphylococcal disease of the skin usually results in a localized collection of pus, known as an abscess, boil, or furuncle. The affected area may be red, swollen, and painful. Drainage of pus is common.

What types of diseases are caused by Staph?

Staph infections of the skin can progress to **impetigo** (a crusting of the skin) or **cellulitis** (inflammation of the connective tissue under the skin, leading to swelling and redness of the area). In rare cases, a serious complication known as **scalded skin syndrome** (see below) can develop. In breastfeeding women, Staph can result in **mastitis** (inflammation of the breast) or in abscess of the breast. Staphylococcal breast abscesses can release bacteria into the mother's milk.

When the bacteria enter the bloodstream and spread to other organs, a number of serious infections can occur. Staphylococcal pneumonia predominantly affects people with underlying lung disease and can lead to abscess formation within the lungs. Infection of the heart valves (endocarditis) can lead to heart failure. Spread of Staphylococci to the bones can result in severe inflammation of the bones known as osteomyelitis. Staphylococcal sepsis (widespread infection of the bloodstream) is a leading cause of shock and circulatory collapse, leading to death, in people with severe burns over large areas of the body.

Staphylococcal food poisoning is an illness of the bowels that causes nausea, vomiting, diarrhea, and dehydration. It is caused by eating foods contaminated with toxins produced by *Staphylococcus aureus*. Symptoms usually develop within one to six hours after eating contaminated food. The illness usually lasts for one to three days and resolves on its own. Patients with this illness are not contagious, since toxins are not transmitted from one person to another.

Toxic shock syndrome is an illness caused by toxins secreted by *Staph aureus* bacteria growing under conditions in which there is little or no oxygen. Toxic shock syndrome is characterized by the sudden onset of high fever, vomiting, diarrhea, and muscle aches, followed by low blood pressure (hypotension), which can lead to shock and death. There may be a rash resembling sunburn, with peeling of skin. Toxic shock syndrome was originally described and still occurs especially in menstruating women using tampons.

1 | 2 | Next »

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Exhibit #A-04

MRSA Cleaning Products, Jon-Don

"What you need to know to protect yourself
and others from MRSA"

3 Pages



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What you need to know to protect yourself and others from MRSA

What is MRSA aka "The Super-Bug?"

MRSA is a form of staph infection that is resistant common antibiotics, making it exceptionally difficult to treat. Staph infections including MRSA have primarily been hospital borne infections, but in the 1990s, a type of MRSA began showing up in the wider community. Today, that form of staph, is known as community-associated MRSA. MRSA causes skin and soft tissue infections and can lead to pneumonia even death.

How is MRSA spread?

Like other staph infections, MRSA is passed from person to person through direct contact with skin or through contact with contaminated items. The bacteria may live in people's noses and on their skin, and usually don't cause any problems. However, young children, the elderly and individuals with immune deficiencies are at particular risk.

What can be done to prevent MRSA infections?

Personal Hygiene Tips Wash hands using liquid soap and water frequently, especially after using the toilet and after any hands-on contact with other persons. Alternatively, an alcohol-based hand rub can be used according to label instructions. Visibly soiled hands should be washed with soap and water rather than an alcohol-based hand rub.

- Dry hands with disposable paper towels or air blowers. Avoid sharing towels.
- Limit sharing of personal items (e.g., towels clothing and soap).
- Keep skin lesions (e.g., boils, insect bites, open sores or cuts) covered with a clean, dry dressing.
- Use a barrier (e.g., a towel or a layer of clothing) between the skin and shared equipment

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- Shower if there has been substantial skin-on-skin contact with another person.
- Athletes with active skin and soft tissue infections should not participate in wrestling until wounds are completely healed. Consider using this rule for all contact sports.

Facility Maintenance Recommendations

Potentially contaminated surfaces should be cleaned with a disinfectant-cleaner-sanitizer such as Microban QGC, an EPA-registered product labeled effective against MRSA. Following label directions, Microban QGC is a safe, economical and effective disinfectant-cleaner-sanitizer all in one application.

- Always wear gloves when using any disinfectants.
 - Hard surfaces and equipment such as floors, drinking fountains, light switches, door handles, handrails, tables and desks should be cleaned routinely.
 - Athletic equipment and areas such as wrestling mats, wall padding, locker rooms, and shower facilities should also be cleaned routinely.
 - If during a sporting event there is a release of bodily fluids (blood, pus or drainage) cleaning and disinfecting should be completed before the activity is allowed to continue.
 - Participate in ongoing assessment and training for appropriate disinfection practices at the facility.
- Facility Maintenance – Athletic Areas
- All hard surfaces that may come in contact with body fluids should be cleaned and disinfected daily with a 2-ounce-per-gallon dilution of Microban QGC, including benches, weights, workout machines, etc.
 - All floors/wall padding in athletic settings should be washed daily (if room is used.)
 - Locker rooms, including any shower areas should be cleaned daily, if used.
 - If soap is furnished, it should be accessible from a wall dispenser.
 - Ensure that athletic areas, locker rooms and restrooms all have separate cleaning mops and buckets, and that all mops (washable microfiber heads or disposable mop cloths) and buckets are cleaned regularly.
 - Consider making spray bottles of disinfectant available for patrons and staff to clean frequently touched surfaces of shared equipment between uses and provide instruction (e.g., new user orientation or posters) for the safe use of disinfectant

Facility Maintenance – Laundry

- Wash shared linens (e.g., towels, sheets, blankets or uniforms) in detergent and water at 160°F for at least 25 minutes.
- Use a mechanical dryer on hot temperature cycle (i.e., avoid air drying)
- Distribute towels, uniforms, etc. only when they are completely dry.

Disinfectant Recommendations

The key to preventing the spread of MRSA is the use of an EPA-registered disinfectant, cleaner and sanitizer. Microban®

*QGC (US-MBQGC) is a multi-purpose, quaternary disinfectant cleaner and sanitizer proven to combat and kill bacteria including MRSA. Microban QGC also offers virucidal (HIV-1 and the AIDS virus) and fungicidal protection as well as inhibits the growth of mold and mildew. Microban QGC meets the EPA standards for hospital disinfectant. **Microban QGC is so effective, it can be used in residences, commercial institutions, daycare centers, nurseries or restaurants on a daily basis.** Additionally, QGC is a highly effective sanitizer for both porous and non-porous hard surfaces, including carpeting, and leaves behind a delightful lemon or mint scent.*

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Exhibit # A-05

The Healia Health Blog

"Health news, health search on Staphylococcus"

1 page

The Healia® Health Blog

Health news. Health search.

So what is Staphylococcus?

Staph infection is caused by a bacterium called Staphylococcus. There are different types ranging from simple boils to flesh-eating infections. The most common type of infection, cellulitis, affects the skin's deeper layers. It might begin as a small area of inflammation – tenderness, swelling, or redness on the skin's surface, or as an open skin sore or ulcer. This type of infection is usually treatable with antibiotics. Over the years, the bacteria, identified as Methicillin-resistant Staphylococcus aureus (MRSA), have grown increasingly resistant to antibiotics.

Due to the highly contagious nature of MRSA, hospitals have been a breeding ground:

According to the Centers for Disease Control and Prevention, health care-associated infections account for an estimated 1.7 million infections and 99,000 associated deaths each year in American hospitals.

Hospitals are particularly concerned about containing the spread of infections by drug-resistant bacteria like MRSA. Several hospitals nationwide will start testing arriving patients for MRSA, in an attempt to isolate the infection and lower infection rates.

To search for more information on staph infection, visit www.healia.com.

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Posted by The Healia Team 3 months ago

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MRSA News Alert

On December 9th, 2007 Anonymous says:

Technology is available to reduce exposure to infectious germs and deadly bacterias such as MRSA. Tests conducted by Kansas State University and Cincinnati State University are posted on the web site for public knowledge.

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Article: <http://www.mayoclinic.com/health/mrsa/DS00735/DSECTION=8>

MRSA infection

Introduction

Methicillin-resistant *Staphylococcus aureus* (MRSA) infection is caused by *Staphylococcus aureus* bacteria — often called "staph." Decades ago, a strain of staph emerged in hospitals that was resistant to the broad-spectrum antibiotics commonly used to treat it. Dubbed methicillin-resistant *Staphylococcus aureus* (MRSA), it was one of the first germs to outwit all but the most powerful drugs. MRSA infection can be fatal.

Staph bacteria are normally found on the skin or in the nose of about one-third of the population. If you have staph on your skin or in your nose but aren't sick, you are said to be "colonized" but not infected with MRSA. Healthy people can be colonized with MRSA and have no ill effects. However, they can pass the germ to others.

Staph bacteria are generally harmless unless they enter the body through a cut or other wound, and even then they often cause only minor skin problems in healthy people. But in older adults and people who are ill or have weakened immune systems, ordinary staph infections can cause serious illness.

In the 1990s, a type of MRSA began showing up in the wider community. Today, that form of staph, known as community-associated MRSA, or CA-MRSA, is responsible for many serious skin and soft tissue infections and for a serious form of pneumonia.

Signs and symptoms

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Staph infection

Staph infections, including MRSA, generally start as small red bumps that resemble pimples, boils or spider bites. These can quickly turn into deep, painful abscesses that require surgical draining. Sometimes the bacteria remain confined to the skin. But they can also burrow deep into the body, causing potentially life-threatening infections in bones, joints, surgical wounds, the bloodstream, heart valves and lungs.

Causes

Although the survival tactics of bacteria contribute to antibiotic resistance, humans bear most of the responsibility for the problem. Leading causes of antibiotic resistance include:

- **Unnecessary antibiotic use in humans.** Like other superbugs, MRSA is the result of decades of excessive and unnecessary antibiotic use. For years, antibiotics have been prescribed for colds, flu and other viral infections that don't respond to these drugs, as well as for simple bacterial infections that normally clear on their own.
- **Antibiotics in food and water.** Prescription drugs aren't the only source of antibiotics. In the United States, antibiotics can be found in beef cattle, pigs and chickens. The same antibiotics then find their way into municipal water systems when the runoff from feedlots contaminates streams and groundwater. Routine feeding of antibiotics to animals is banned in the European Union and many other industrialized countries. Antibiotics given in the proper doses to animals who are sick don't appear to produce resistant bacteria.
- **Germ mutation.** Even when antibiotics are used appropriately, they contribute to the rise of drug-resistant bacteria because they don't destroy every germ they target. Bacteria live on an evolutionary fast track, so germs that survive treatment with one antibiotic soon learn to resist others. And because bacteria mutate much more quickly than new drugs can be produced, some germs end up resistant to just about everything. That's why only a handful of drugs are now effective against most forms of staph.

Risk factors

Because hospital and community strains of MRSA generally occur in different settings, the risk factors for the two strains differ.

Risk factors for hospital-acquired (HA) MRSA include:

- **A current or recent hospitalization.** MRSA remains a concern in hospitals, where it can attack those most vulnerable — older adults and people with weakened immune systems, burns, surgical wounds or serious underlying health problems. A 2007 report from

the Association for Professionals in Infection Control and Epidemiology estimates that 1.2 million hospital patients are infected with MRSA each year in the United States. They also estimate another 423,000 are colonized with it.

- **Residing in a long-term care facility.** MRSA is far more prevalent in these facilities than it is in hospitals. Carriers of MRSA have the ability to spread it, even if they're not sick themselves.
- **Invasive devices.** People who are on dialysis, are catheterized, or have feeding tubes or other invasive devices are at higher risk.
- **Recent antibiotic use.** Treatment with fluoroquinolones (ciprofloxacin, ofloxacin or levofloxacin) or cephalosporin antibiotics can increase the risk of HA-MRSA.

These are the main risk factors for community-acquired (CA) MRSA:

- **Young age.** CA-MRSA can be particularly dangerous in children. Often entering the body through a cut or scrape, MRSA can quickly cause a wide spread infection. Children may be susceptible because their immune systems aren't fully developed or they don't yet have antibodies to common germs. Children and young adults are also much more likely to develop dangerous forms of pneumonia than older people are.
- **Participating in contact sports.** CA-MRSA has crept into both amateur and professional sports teams. The bacteria spread easily through cuts and abrasions and skin-to-skin contact.
- **Sharing towels or athletic equipment.** Although few outbreaks have been reported in public gyms, CA-MRSA has spread among athletes sharing razors, towels, uniforms or equipment.
- **Having a weakened immune system.** People with weakened immune systems, including those living with HIV/AIDS, are more likely to have severe CA-MRSA infections.
- **Living in crowded or unsanitary conditions.** Outbreaks of CA-MRSA have occurred in military training camps and in American and European prisons.
- **Association with health care workers.** People who are in close contact with health care workers are at increased risk of serious staph infections.

When to seek medical advice

Keep an eye on minor skin problems — pimples, insect bites, cuts and scrapes — especially in children. If wounds become infected, see your doctor. Ask to have any skin infection tested for MRSA before starting

antibiotic therapy. Drugs that treat ordinary staph aren't effective against MRSA, and their use could lead to serious illness and more resistant bacteria.

Screening and diagnosis

Doctors diagnose MRSA by checking a tissue sample or nasal secretions for signs of drug-resistant bacteria. The sample is sent to a lab where it's placed in a dish of nutrients that encourage bacterial growth (culture). But because it takes about 48 hours for the bacteria to grow, newer tests that can detect staph DNA in a matter of hours are now becoming more widely available.

In the hospital, you may be tested for MRSA if you show signs of infection or if you are transferred into a hospital from another healthcare setting where MRSA is known to be present. You may also be tested if you have had a previous history of MRSA.

Treatment

Both hospital and community associated strains of MRSA still respond to certain medications. In hospitals and care facilities, doctors generally rely on the antibiotic vancomycin to treat resistant germs. CA-MRSA may be treated with vancomycin or other antibiotics that have proved effective against particular strains. Although vancomycin saves lives, it may grow resistant as well; some hospitals are already seeing outbreaks of vancomycin-resistant MRSA. To help reduce that threat, doctors may drain an abscess caused by MRSA rather than treat the infection with drugs.

Prevention

Hospitals are fighting back against MRSA infection by using surveillance systems that track bacterial outbreaks and by investing in products such as antibiotic-coated catheters and gloves that release disinfectants.

Still, the best way to prevent the spread of germs is for health care workers to wash their hands frequently, to properly disinfect hospital surfaces and to take other precautions such as wearing a mask when working with people with weakened immune systems.

In the hospital, people who are infected or colonized with MRSA are placed in isolation to prevent the spread of MRSA to other patients and healthcare workers. Visitors and healthcare workers caring for isolated patients may be required to wear protective garments and must follow strict handwashing procedures.

What you can do in the hospital

Here's what you can do to protect yourself, family members or friends from hospital-acquired infections.

- Ask all hospital staff to wash their hands or use an alcohol-based hand sanitizer before touching you — every time.
- Wash your own hands frequently.
- Make sure that intravenous tubes and catheters are inserted under sterile conditions, for example, the person inserting them wears a mask and sterilizes your skin first.

What you can do in your community

Protecting yourself from MRSA in your community — which might be just about anywhere — may seem daunting, but these common-sense precautions can help reduce your risk:

- **Wash your hands.** Careful hand washing remains your best defense against germs. Scrub hands briskly for at least 15 seconds, then dry them with a disposable towel and use another towel to turn off the faucet. Carry a small bottle of hand sanitizer containing at least 62 percent alcohol for times when you don't have access to soap and water.
- **Keep personal items personal.** Avoid sharing personal items such as towels, sheets, razors, clothing and athletic equipment. MRSA spreads on contaminated objects as well as through direct contact.
- **Keep wounds covered.** Keep cuts and abrasions clean and covered with sterile, dry bandages until they heal. The pus from infected sores may contain MRSA, and keeping wounds covered will help keep the bacteria from spreading.
- **Shower after athletic games or practices.** Shower immediately after each game or practice. Use soap and water. Don't share towels.
- **Sit out athletic games or practices if you have a concerning infection.** If you have a wound that's draining or appears infected — for example is red, swollen, warm to the touch or tender — consider sitting out athletic games or practices until the wound has healed.
- **Sanitize linens.** If you have a cut or sore, wash towels and bed linens in a washing machine set to the "hot" water setting (with added bleach, if possible) and dry them in a hot dryer. Wash gym and athletic clothes after each wearing.
- **Get tested.** If you have a skin infection that requires treatment, ask your doctor if you should be tested for MRSA. Doctors may prescribe drugs that aren't effective against antibiotic-resistant

staph, which delays treatment and creates more resistant germs. Testing specifically for MRSA may get you the specific antibiotic you need to effectively treat your infection.

- **Use antibiotics appropriately.** When you're prescribed an antibiotic, take all of the doses, even if the infection is getting better. Don't stop until your doctor tells you to stop. Don't share antibiotics with others or save unfinished antibiotics for another time. Inappropriate use of antibiotics, including not taking all of your prescription and overuse, contributes to resistance. If your infection isn't improving after a few days of taking an antibiotic, contact your doctor.

By Mayo Clinic Staff
Nov 9, 2007

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